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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Significance of Uterine and Vaginal Discharges. By ROBERT BARNES, M.D., Obstetric Physician to St. Thomas's Hospital, etc. etc.

Discharges of Air.—Air may get into the vagina, if not into the uterus, in the non-pregnant state. In the normal condition the walls of the vagina are maintained in perfect contact, and no air, or probably very little, is admitted. But where the parts are greatly relaxed, the vulva open as when the perineum is torn, the lower part of the vagina is no doubt exposed to the contact of air. But the very condition of patency prevents the retention of the air to such a degree as to lead to its escape in perceptible volume. Air also penetrates where too large a pessary is worn, which keeps the vaginal walls apart. But under peculiar circum-

stances air enters in large quantity, to be expelled with noise. Dr. George Harley details¹ a curious case in which he carried out decisive experiments to prove the correctness of the diagnosis. A pluripara frequently expelled air from the vagina with a loud noise. It was ascertained that no connection existed between the rectum and vagina. Dr. Harley took a full-sized male catheter, to which was attached a long India-rubber tube with a stopcock at the other end. The catheter was introduced into the uterus, the end of the tube with the stopcock being placed in a tumblerful of water. No air escaped when the instrument was in this position; but, on placing the open end of the catheter, in the vagina, an instantaneous discharge of gas took place. The water was found to be sucked up through the tube into the vagina. It was found that the

¹ Obstetrical Transactions, 1863.

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vagina sucked in and expelled the air by spasmodic action. It was further observed that the abdominal muscles assisted in the suction process. The uterus was completely retroverted. This displacement being remedied, and the patient's health improved by tonics, a cure ensued.

If you observe the vagina when the duck-bill speculum is applied, you will see movements of rise and fall under the influence of the rise and fall of the diaphragm. Dr. Adolph Rasch has investigated¹ the phenomena with great care. He says, if a multipara whose genitals are normal be placed on her back, with the thighs flexed and abducted, and the vaginal orifice closed, movements caused by respiration are seen, but no air enters. In the lateral position the same thing is observed even if the vagina is lax, and even when the perineum is ruptured. When the patient is placed in the prone position, or on all-fours, if the vulva be open, air will enter, because the intestines falling downwards by gravity cause a vacuum. Under this condition violent exertion may expel air, giving rise to vaginal flatus. If the abdomen be supported by the hands or by a bandage, no air enters.

There are several interesting applications of this knowledge. It teaches that the best position after labour, if not during labour also, is the dorsal; that the same position is also best in the case of pelvic abscess or hæmatocele discharging into the vagina; and that we must carefully consider this respiratory rise and fall of the vagina when selecting pessaries. It is by turning to account this action that we derive the greatest advantage from the spoon or Sims's speculum. The blade drawing the perineum well back, whilst the semi-prone position of the patient favours the falling forwards of the abdominal viscera, air fills the vagina, counteracts the effect of inspiration, and thus enables us to get a good view of the os uteri. The same position also greatly aids our efforts at reducing inversion of the uterus, and in replacing a prolapsed umbilical cord. In most operations, how-

ever, upon the uterus and vagina, where it is of importance to bring the uterus as low down near the vulva as possible, the dorsal position, by bringing the force of gravity to counteract the respiratory rise of the uterus, which can further be greatly aided by direct pressure by an assistant's hand above the symphysis pubis, is the best.

If we were to follow out in detail all the indications supplied by the examination of the discharges, we should be led through almost the entire range of uterine and vaginal pathology. This, in fact, is simply the converse proposition to one already stated—namely, that almost every uterine or vaginal disease is attended by discharge. But to adopt the discharges as our point of departure, from which to proceed to study and classify the diseases of which they are consequences, would be a most intricate course, and not the most orderly or profitable. I will therefore not pursue this method further than to give one instance of how we may apply it to clinical analysis. We will at our next meeting take hemorrhage, and sketch what its purport is.

The Watery Discharges.—When these occur, you must first of all determine the presence or absence of pregnancy. It is no uncommon thing that discharges of water, more or less profuse, take place in pregnant women. This is the *hydrorrhœa gravidarum*. Gushes of water, quite clear, may occur at almost any time during pregnancy; but they are more frequent in the latter months, and especially in the last month. Happening at this time, they are commonly taken as an indication of commencing labour, and many are the false alarms which patient and doctor have to suffer from this cause. "The waters have broke," says the nurse. You go, as in duty bound, and find probably the os uteri closed, nothing resembling active labour-pains. What are you to do? If you wait for labour, you may wait for a week, or two or three weeks. If, on examination by ballottement, you find the child still floats in the uterus, the os uteri not open, and no active pains, you may go home and wait in peace for another summons.

What is the source and nature of this

¹ *Ibid.*, 1870.

hydrorrhœa gravidarum? Several theories have been expounded. The character of the fluid differs in some respects from that of liquor amnii. It is odourless, and resembles blood-serum, or the serous fluid effused in the peritoneal sac. Ruysch and Røderer thought it came from ruptures of lymphatic vessels, or of hydatids of the uterus; Böhmer thought it escaped from a second abortive ovum; Delamotte and Cruveilhier that it came from a cyst near the ovum; Deleurye, Puzos, Naegele, and Dubois that it came from the inner surface of the uterus, being secreted externally to the ovum. Dubois says it is the result of loosening of the membranes from the uterus when the vessels pour out serum. Hegar says the source is the uterine glands of the decidua. Thus, he describes¹ the glands of the mucous membrane as being found in the decidua at the sixth month of gestation, and argues that their sudden disappearance in the subsequent months is improbable. In a case of hydrorrhœa he found in the decidua vera, at the beginning of the eighth month, an enormously developed glandular body. At the bottom of this morbid growth was a general hypertrophic condition of the decidua and its glands. These gave out the excessive secretions. In a case related by Dr. Graef,² repeated discharges took place, and the fœtus was expelled at the end of six months. The membranes were very delicate, and openings were found in them. In this case, it is probable that the fluid was true liquor amnii. In another case the patient suffered, during the last three months, from repeated watery discharges; the uterus rising and falling with the gathering and escape of the fluid. The membranes were found without rent. Graef regarded this as a case of catarrhal hydrorrhœa.

I believe there are various sources. In some cases the fluid is liquor amnii. This may come either from rupture of the membranes; from rapid transudation under pressure; from rapid formation and accumulation of liquor amnii in the amnion; or from the bursting of a cyst formed be-

tween the amnion and chorion, or between two layers of chorion, the proper amniotic sac remaining intact. In the majority of cases, however, the fluid is not amniotic; for when once the amniotic sac has fairly ruptured, labour is not far off. It is, then, the result of a rapid secretion from the uterine glands, or from the cervical cavity. In the early months, whilst there is still a free space between the decidua vera and the decidua reflexa, there is a large area of developed glandular surfaces.

I have observed a *puerperal form of hydrorrhœa*. Thus, watery discharges may continue for a month or longer beyond the proper lochial flow. Generally in these cases the water is dirty, discoloured, occasionally stained with blood, and offensive. The most common cause I have found to be the retention of a portion of placenta, or of clots in the uterus; but a polypus may produce like results. The watery discharges alternate, but not always, with discharges of blood. The fluid may, under certain conditions, collect in considerable quantity in the uterus, so that the organ becomes greatly distended before the collection is expelled in a gush.

Sometimes watery fluid is mingled with air, constituting *phæo-hydrometra*. This is also a puerperal or post-puerperal condition, and is commonly the result of retention of some portion of placenta or membranes, and the admission of air into the uterine cavity. If an examination is made when the uterus is relaxed after labour, especially if the hand be introduced into the uterus, the vaginal walls are separated from their usual contact, and a channel is formed along which air easily enters. Merely turning on the side, or a little more prone, will often, by favouring the fall of the uterus forwards, produce a vacuum into which air will rush. This is one reason amongst others why I am unable to approve of the abolition of the old-fashioned binder, which some people would condemn for no better reason than that I can see than because it is old-fashioned. After labour, especially in pluriparæ, the abdominal walls are so relaxed that they can give no support to the uterus. The binder does temporary

¹ Monatschrift für Geburtakunde, 1863.

² Jenaische Zeitschrift, 1865.

duty for the inert abdominal walls. The history of physio-hydrometra is, I believe, this: a portion of placenta, membranes, or clots remains in the cavity of the uterus after labour; some air gets in as I have described; decomposition ensues, and the gases of putrefaction are added to the air from without, whilst the os uteri is occluded by the placenta or blood-mass falling over it. When this occurs, there is invariably hectic or irritative fever; peritonitis and septicæmia commonly attend; great abdominal pain; the enlarged, distended uterus can be mapped out rising as high as, or higher than, the umbilicus; and resonance is made out on percussion.

One condition, the result of impregnation, often leads to copious and repeated discharges of watery fluid; the *hydatidiform degeneration of the chorion*. In this case the ordinary signs of pregnancy may not be present, and even the patient herself may not think she is pregnant. There is, however, always evidence of enlargement of the uterus, and generally great pelvic distress. The water escapes in gushes at uncertain times; it is often tinged with blood, resembling red-currant water; it has not the offensive odour belonging to the watery discharges of cancer; sometimes, but not often until late in the progress of the case, cysts will be found swimming in the water; it is generally expelled with painful uterine contractions. In a case we recently had in Adelaide ward, the nature of the disease was not at first suspected. There was some abdominal enlargement, retention of urine requiring the catheter, and most distressing pelvic pain with irritative fever. The os uteri was found high up above the symphysis pubis, whilst behind it the pelvic cavity was filled with a large, rounded, firm mass taken to be either the retroverted gravid womb, or a fibroid tumour. One day a large quantity of water, blood, and a mass of chorion-cysts were expelled. We had, in fact, the condition of retroverted gravid womb complicated with hydatidiform or cystic degeneration of the chorion.

Apart from pregnancy, watery discharges are often of grave significance. During and after the climacteric period, the most frequent cause is some form

of malignant disease, especially the so-called cauliflower excrescence of the uterus. In this case other symptoms will probably point to the seat and nature of the disease. The fluid discharged is seldom clear; it is generally turbid, dirty, often tinged with blood, resembling water in which flesh has macerated; it contains shreds or flocculi of solid matter, the proceeds of superficial erosion or necrosis of the surface of the diseased growth, and is almost always of a peculiar offensive odour. It often alternates with hemorrhage. Local exploration will place the nature of the case beyond doubt. Another form of malignant disease giving rise to watery discharges is the "oozing excrescence of the labia."

But we must remember that similar discharges may take place from polypus or inversion of the uterus. Hence we have another example of the wisdom of not pronouncing a diagnosis until we have made an internal examination. Water may escape in large quantity from the rupture or perforation of an ovarian cyst into the vagina. In such a case, the rapid concurrent diminution of the abdominal tumour will lead to the right conclusion.—*Lancet*, Feb. 10, 1872.

Abstract of a Clinical Lecture on a Case of Spina Bifida cured by Injection. By JAMES MORTON, M.D., Surgeon and Clinical Lecturer, Glasgow Royal Infirmary.

John K., æt. 2 months, was admitted into the Glasgow Royal Infirmary Oct. 2, 1871, with a tumour opposite the upper lumbar vertebrae, globular in shape, of about the size of a small orange, and presenting the usual appearances of a case of spina bifida. Its covering was thin, so that it was quite translucent; and at the child's birth it was about half its present size. The mother stated that the tumour felt harder and fuller when the child cried. Moderate pressure upon it did not cause much inconvenience or suffering; and the child had never had convulsions, and seemed in all other respects quite healthy; the fontanelles being neither more open nor more full than usual at the same age.

On October 12th, the tumour was punctured with a grooved needle, and rather more than half of its contents—a pale,

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straw-coloured fluid—was removed. It was then covered with lint dipped in oil, and over this cotton-wool; and, to fix the whole and afford a slight pressure, a broad elastic band was passed round the waist of the child. The sac speedily refilled, and on the 18th was punctured a second time; and again it refilled.

On October 24th, the tumour had regained nearly its former size; and to-day it was punctured with a trocar and canula of moderate size. After it had been half emptied, a small portion—probably nearly half a drachm—of the following solution was injected: *R* Iodi gr. x; potass. iodidi ʒss; glycerine ʒj.

On October 26th, the child continued well, having no bad symptoms, and being only a little "fractious." In the swelling, a portion of a soft, solid substance could be felt, rather to one side.

On November 2d, the mother was allowed to take the child home for a day or two; and on the 6th she returned to the Infirmary, when it was evident that some degree of refilling had taken place. The tumour was again injected with a small portion of the same solution. How much actually entered the sac, it was not possible to say. The child, however, continued quite as well as before; and on November 23d he was brought up and shown to the clinical class, when the tumour was found to be smaller and harder than formerly, without any appearance of redistention with fluid.

On December 7th, the child was again shown at the hospital; and now the swelling presented the appearance of a shrivelled bag of skin, darker in colour than the adjacent integument, somewhat resembling a corrugated scrotum, and afforded reason to believe that there was now complete closing of the opening in the spinal membranes. The health of the child was perfect, his mother affirming that he never was so well and comfortable as he was now.

On January 8th, 1872, the child was again brought to the hospital, merely to show that he continued quite well.¹

¹ This patient was shown to the members of the Medico-Chirurgical Society at the meeting on the 1st February last.

Remarks.—In commenting on this case before the clinical class, a short account was given of the usual appearances presented by such tumours, and the ordinary coverings and contents were noted. Reference was also made to the deficiency in development of the osseous portion of the spinal canal, as the origin of the name, which of itself conveys no idea of the importance of the contents; and remarks were further made to the following effect: It is in reality a local dropsy, consisting of a collection of serum within the serous covering of the spinal cord; and, too often for the safety of the patient, there is also a portion of the nerve-structure of the cord, which has left its proper line, and lies extended under the serous lining of the sac, just under the skin, running, as it were, round or half round the circumference of the swelling, which is often globular, as in this instance. It is this condition chiefly which renders interference with such cases hazardous, and which presents to the mind of the surgeon the possibility of the nervous matter of the cord being so disturbed as to lead to very violent and dangerous manifestations of the effects of irritation of such tissues, in the form of convulsions, which not seldom terminate fatally. Even when left to nature, the rule seems to be, that the subjects of such malformations die, and that early—within the first or second year. To this, it is well known, there are exceptions; still it is the rule. Attempts are usually made by relatives, under professional advice, to protect the part by the use of hollow cup-like shields, lined with cotton, and most carefully attended to; but the result is disappointment, so far as life is concerned. These tumours are far more common in the lumbo-sacral region than in all the other portions of the spine put together; and this is an example of one in the lumbar region.

Treatment.—Allusion has been made to the palliative or protective treatment, as we may venture to call it; and we now turn our attention to the modes of attempting the radical cure, and give shortly our reasons for adopting the plan which has been so fortunate in the present instance. Though it may be true that ac-

tive surgical interference usually hastens death, yet cases have recovered after various kinds of treatment. The presence of the cord, and the free communication with the serous covering of the spine and the brain, are the chief obstacles to success. Inflammation of the cord or its membranes, or gangrene of the cord, causing paralysis, may occur, speedily ending in death. Even when left untouched, the skin often ulcerates, the sac bursts, and palsy or convulsions cause death. A spontaneous cure has been known to take place, the orifice of communication having closed, the tumour becoming a closed cyst, and remaining innocuous, or it may be removed. Rupture of the sac has even been followed by recovery. Three modes of interference present themselves—*injection, ligature, and excision*; and of these three modes, it may be said that each of them has been effected by a variety of means and appliances, which it is not my purpose to enumerate at present. Suffice it to say, that I resolved to adopt the first of these, as, in my opinion, the least dangerous of the three. It will be noticed that twice I punctured the sac with a grooved needle, and drew off a considerable quantity of the fluid. These may be called tentative measures, to ascertain whether the membranes could be pierced with safety; and, no suffering or derangement of function having followed, I felt encouraged to use an iodine solution. In forming this solution, I resolved to use glycerine as the solvent; for the reason that it is a fluid of less diffusibility than a spirituous or even a watery solution. Not that I for a moment imagine that it could not be conveyed along the serous cavity or the serous lining of the spine; still, to my mind, it offered one element of greater security. The strength of the solution may be noted; but then it must be observed that, in using it, the sac was purposely only half emptied of its serum when the iodine solution was injected; and of the latter only about half a drachm was actually injected, so that the then ioduretted contents of the sac presented a very dilute solution. When the repetition of the injection was made, somewhat more of the iodine fluid was used;

but part of it escaped and was lost, so that, as the report states, it was not possible to estimate correctly the amount retained. A degree of solidification followed the first injection; and after the second it became complete, and now remains so, the part admitting of ordinary handling without inconvenience or discomfort to the child.

A line of treatment very similar to this has been followed by several of the American surgeons, and with instances of success; but statements are discordant in regard to the proportion which the successes bear to the failures. Several British surgeons have also operated successfully in a limited number of cases and by various methods, but most frequently by injection with iodine as the coagulating or stimulating agent; but I am not aware of glycerine having been used as a solvent on any previous occasion, and I may indulge the hope that others may be induced to try it.

From what I have seen of such cases, it is my belief that the fluid should not be allowed to drain completely from the sac: this leads to fatal results; and, where a puncture has been made, the aperture, however minute, may be closed and guarded by a layer or layers of collodion, especially when subsequent oozing is feared or perceived.—*Brit. Med. Journ.*, April 6, 1872.

HOSPITAL NOTES AND GLEANINGS.

On the Value of Observations of the State of the Pupils in the Diagnosis of the Position or Nature of the Lesions in Acute Cases of Cerebral Disease. By HURLINGS JACKSON, M.D.—In cases of apoplexy, the pupils are always examined; but they are sometimes put down as being "contracted" or "dilated" without due consideration. In some cases of fatal apoplexy from cerebral hemorrhage, the pupils cannot be said to be altered in size, for there is nothing remarkable about their size. The pupils differ in size in different people and at different ages; and thus it occasionally happens that, when a patient is apoplectic, we are really not warranted in saying that they are larger or smaller than they were before the attack. It is better, in these cases, to use the words large or small, than the technical terms which imply that

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there is an alteration in size from the recent cerebral lesion. *Extreme* contraction of both pupils is, when there is also universal powerless and deep coma, evidence of large hemorrhage in the pons Varolii; but, as this condition of the pupils is found in cases of poisoning by opium (from which also there result coma and universal powerlessness), the diagnosis betwixt these two forms of apoplexy is sometimes impossible. When the patient is found comatose, there being no history to show in what way his illness set in, we cannot make a diagnosis, unless, for instance, we find an emptied laudanum bottle. On the other hand, it is quite certain that, in some cases of large hemorrhage into other parts of the encephalon, there is extreme contraction of the pupils. Again, in a few cases of fatal hemorrhage into the pons, the pupils are not minutely contracted. In cases of apoplexy, either from cerebral hemorrhage or from poisoning by opium, contracted pupils will dilate shortly before death.

Two observers may come to different conclusions as to the size of the pupils in the same case of apoplexy, if they observe them when the patient is in different conditions. It often happens that the pupils of a comatose patient are very small—as small as they are in healthy sleep—whilst he lies undisturbed; but, when he has been aroused by examinations of his limbs, or by pinching or shaking, the pupils will become much larger, presumably of their normal size. This is so when the patient can be only roused to vague movements of fretful resistance, and not to anything like real consciousness. Unless these facts be borne in mind, we may err in supposing there to be remarkable variations in the size of the pupils during the course of a case of apoplexy.

Inequality of the pupils is of more value in diagnosis, but not unless the pupils be of *very* different sizes. If, in a case of injury to the head, one pupil be very large, there is probably, Mr. Hutchinson says, large effusion of blood in the sphenoidal fossa of the side of the dilatation. Great contraction of one pupil occurs from lesion of the same side of the pons Varolii, but not always. No doubt the precise seat of

the lesion makes a difference. In a case of inequality of the pupils, observed in a patient who died apoplectic from injuries to the head, the cause of inequality was seen, on instillation of atropia, to be the existence of iritic adhesions. Oddly enough, a confident prediction as to the side on which the cerebral lesion would be discovered at the necropsy (founded on the difference in the size of the pupils), turned out to be correct. In another case, contraction of the pupil, put down to some affection of the cervical sympathetic, was thus explained away.

In most cases of *severe* convulsion, whatever the cause of seizure may be, the pupils dilate very widely during the paroxysm. In one case of convulsion with extensive intracranial hemorrhage, the pupils became very wide, so that Dr. Hughlings Jackson was able to see the optic disk by the aid of the ophthalmoscope. When the convulsion had passed off, the pupils were so small that the disks could not be seen until after the use of atropia.

On the whole, observations on the state of the pupils are not as yet proved to be of much value in the diagnosis either of the position or of the nature of lesions in acute cases of cerebral disease.—*Brit. Med. Journ.*, April 6, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

American Medical Association.—As we have already announced, the annual meeting of this Association will be held at Horticultural Hall, Broad Street below Locust, in the city of Philadelphia, on Tuesday, May 7, 1872, at 11 o'clock A.M.

The Secretary will be in attendance at the Horticultural Hall on Monday, May 6th, and all duly accredited delegates who may be in the city on that day are requested to present themselves for registration.

The annual exhibition, which is to be held in the Hall of the College of Physicians, N. E. corner of Locust and Thirteenth Streets, will be open daily throughout the week, commencing Monday, May 6th.

The Municipal Hospital of Philadelphia.

—The report for 1871, of Dr. WILLIAM M. WELCH, Physician in Charge of the Municipal Hospital, contains a number of facts in reference to the admission and treatment of patients in that institution. The hospital ordinarily has a capacity for 190 beds, but in consequence of the prevalence of the smallpox, temporary improvements were made so as to accommodate 312, the highest number under treatment at any one time. During the past year 1227 patients with variolous diseases and 22 with other diseases were admitted, of which 677 were variola (smallpox) cases, and 550 varioloid; of the former 353, or 52.14 per cent., died; and of the latter only 8, or 1.45 per cent., died. The ages of those admitted were as follows:—

Ages.	Admitted.	Died.	Per cent. of Deaths.
Under 1 year	12	10	83.33
1 to 15 years	162	60	37.00
15 to 25 years	599	185	30.88
25 to 45 years	383	108	28.19
45 years and upwards .	71	24	33.8
Total	1227	387	31.54

In making a differential diagnosis between the two varieties of the disease, Dr. Welch paid no regard as to whether his patients had or had not been vaccinated, except to classify all unvaccinated cases, no matter how mild, as variola. He classified all cases as varioloid where the patients had been vaccinated. In all the deaths from varioloid (or vaccinated cases) there has been either some constitutional peculiarity, or some intercurrent disease that has been auxiliary in terminating life. In reference to vaccination, the doctor states that variola, or smallpox, in unvaccinated infants, is almost uniformly fatal, and that vaccination performed less than seven days prior to the appearance of the eruption will not modify the disease; but when performed as long as seven or eight days prior, it may so far modify the disease as to render it harmless. The following table shows the number of patients vaccinated and not vaccinated, number of deaths and percentage of deaths among "good" and imperfect vaccinations:—

	Admitted.	Died.	Per cent of Deaths.
Vaccinated:			
Good Cicatrix . . .	332	33	9.93
Fair Cicatrix . . .	186	27	16.36
Poor Cicatrix . . .	301	68	22.60
Total vaccinated .	799	128	16.
Not vaccinated . .	390	254	65.12

Dr. Welch classifies as "good cicatrices" all those with a well defined margin, slightly excavated, and pitted or honey-combed, as they are sometimes aptly described, while those presenting these characteristics to a much less degree he classified "fair," and those as "poor" which are so indistinct as to make it difficult to recognize them as vaccine scars. The proportion of deaths among the unvaccinated is enormous—double the ordinary death-rate, which has long been regarded as 33 per cent. Two reasons are assigned for this large mortality: the first and chief being the virulence of the epidemic; the second, that in many instances only the graver cases are sent to the hospital, and many of these not until all hope of recovery is passed.

The above statistics show, conclusively, the great protective powers of a proper vaccination against the mortality from smallpox.

Mortality in Philadelphia from Smallpox.

Week ending March 30	80
" " April 6	74
" " " 13	71
" " " 20	62

The above table shows that the epidemic is steadily decreasing, the mortality having diminished from 233 in the week ending December 2, to 62 in the week ending April 20.

Medical Graduates in 1872 (continued from page 57).—

University of Nashville	84
Chicago Medical College	82
Geneva Medical College (N. Y.) .	12
Missouri Medical College	40
St. Louis Medical College	68
University of Louisiana	58
Washington University (Baltimore, Md.)	57
University of Iowa	16
Indiana Medical College	20

Philadelphia College of Pharmacy.—At the fifty-first annual commencement of this school, on the 15th of March last, the degree of Graduate in Pharmacy was conferred on 59 candidates.

Jefferson Medical College.—We have the pleasure of announcing the election, on the 26th of April, of Dr. J. M. DaCosta to the chair of Practice of Medicine in Jefferson Medical College. The acquisition of the services of so eminent a teacher must redound to the advantage of the school, and tend to maintain the high reputation which Philadelphia has so long enjoyed as a centre of medical instruction.

Bellevue Hospital Medical College.—The following changes have taken place in the Faculty of this College: Prof. B. W. McCready having resigned, Prof. W. A. Hammond will assume the chair of Materia Medica and Therapeutics, and Clinical Medicine, in addition to that of Diseases of the Mind and Nervous System. On the latter branches he will continue his lectures and clinics as heretofore. In consequence of the resignation of Prof. Stephen Smith, Dr. A. B. Crosby has been appointed Professor of Descriptive and Surgical Anatomy. Dr. E. G. Janeway has been made Professor of Pathological Anatomy, and will lecture on that subject in the regular session, while, as Professor of Practical Anatomy, he will act as Demonstrator in place of Dr. Mosely. Prof. Mott relinquishes Surgical Anatomy to the chair of Anatomy, but will hold his Surgical Clinic at the College on Wednesdays throughout the year. A new outdoor medical clinic has been established under charge of Prof. Flint; and a new clinic for Diseases of Children, under charge of Prof. Lusk. Dr. E. L. Keyes has been appointed Prof. of Dermatology. —*New York Med. Journ.*, April, 1872.

OBITUARY RECORD.—It is with deep regret that we record the death, on the 5th of April, at the mature age of 85, of our highly esteemed and nearly life-long friend, SAMUEL JACKSON, M.D., Emeritus Professor of the Institutes of Medicine in the University of Pennsylvania.

It would require a more eloquent pen

than our own to do justice to the eminent merits of Dr. Jackson—to his brilliant genius—his great scientific attainments—his enthusiastic pursuit of knowledge, which kept him constantly in advance of his cotemporaries—his eloquence as a lecturer, which inspired his hearers with much of his own zeal for investigation and for elucidating by observations and experiments the still obscure points in physiology—his remarkable conversational powers—his genial social qualities—his scrupulous integrity, and his kind, liberal, and generous disposition.

The Medical Faculty of the University of Pennsylvania have adopted the following resolutions expressive of their regret at the loss of their colleague, and of their respect for his memory:—

"1. *Resolved*, That the announcement of the death of their venerable colleague, Dr. Samuel Jackson, Emeritus Professor of the Institutes of Medicine, has deeply impressed the Medical Faculty of the University, and quickened the feelings of affectionate respect which they have always entertained for his person and character.

"2. *Resolved*, That to his genius in cultivating medical science, his eloquence in expounding its laws, and his earnestness in enforcing its precepts, the Medical Department of the University is deeply indebted for the fame it enjoyed and the influence it exerted during the long period of his professorship.

"3. *Resolved*, That his ardent temperament, genial disposition, and enthusiastic love of knowledge inspired all who knew him as associate or teacher with an ambition to follow in his footsteps, and adorn, as he adorned, the profession which he ennobled by his character and illustrated by his life-long labours.

"4. *Resolved*, That the Faculty will preserve the memory of Dr. Jackson's character and services as a model for the young to imitate, and a monument to be admired by all who reverence genius, and its practical results in enlarging the field of knowledge and in mitigating the pains and perils of disease."

R. E. ROGERS, M.D.,

Dean of the Medical Faculty.

April 8, 1872.

We are also pained to record the death in this city, on the 31st of March last, aged seventy-four, of SAMUEL HENRY DICKSON, M.D., Professor of the Theory and Practice of Medicine in Jefferson Medical College, Philadelphia. Dr. D. was a highly cultivated, honourable, and urbane gentleman, and one of the bright ornaments of our profession. He filled successively the chair of Practice of Medicine in the Medical College of the State of South Carolina, in the University of the City of New York, and in Jefferson Medical College, and with great credit to himself and advantage to numerous pupils.

At a special meeting of the Faculty of the Jefferson Medical College, convened in reference to the death of their late esteemed colleague, it was—

Resolved, That the members of the Faculty have heard with deep-felt sorrow of the demise of their late distinguished colleague, Samuel Henry Dickson, M.D., LL.D., Professor of the Theory and Practice of Medicine, whose name and fame for the last fourteen years have been connected with this Institution, and for half a century with medical teaching. Ripe in years, and rich in all the honours that could be gathered from the broad fields of science and literature, he has closed a long and active life, made, by his genius and vast experience, most eminently useful in ministering to the relief of the sick, and in the education of a very large portion of the medical profession of this country. A courteous gentleman, a genial and refined associate, always amiable and instructive in his intercourse with his fellows—wise, learned, and accomplished as a teacher—the Faculty of this College and the profession at large may well sorrow over the extinction of a life so rich in usefulness and renown.

Resolved, That the Faculty, in remembrance of his many virtues, and in profound respect to his memory, will pay their last tribute to a loved colleague by attendance at his funeral; and further,

“That a copy of these resolutions be transmitted to his family.”

B. HOWARD RAND, M.D.,

Dean of the Faculty.

At a memorial meeting of the Medical

Society of South Carolina and of the Medical Profession generally, held April 11th, at the Roper Hospital, Charleston, several very eloquent and pertinent addresses eulogistic of the character of Prof. Dickson were delivered, and the following resolutions were adopted:—

Resolved, That, in the recent death of Professor Samuel Henry Dickson, our associate, our colleague, and long-endured friend, this society and our professional brethren at large have sustained a loss which they will deplore with deep and heartfelt grief.

Resolved, That, by this afflictive dispensation, the science of medicine has been deprived of one of her most honourable votaries, the college in which he recently served with such distinguished success a most estimable colleague, society a refined and cultivated ornament, and humanity one who ever felt for the afflicted, and practised a wide-spread benevolence in his efforts to mitigate the afflictions and sorrows of mankind.”

Died in Richmond, Va., March 26, 1872, aged 70 years, ROBERT W. HAXALL, M.D. Dr. H. was an accomplished, skilful, and highly-esteemed physician, and a high-minded and honourable gentleman. He was one of the active founders of the American Medical Association, and was chairman of the committee appointed to report a uniform and more elevated standard of requirements for the degree of M.D., to be adopted by all the medical schools of the United States, and which report met the approval of the Association.

— At Detroit, Michigan, April 5th, aged 85, ZINA FITCHER, M.D. Dr. F. was one of the pioneers of the Northwest, and had many offices bestowed upon him, which he ably filled. In 1822 he was appointed an assistant surgeon U.S.A., and afterwards full surgeon, which post he held until 1836, when he became a citizen of Michigan, and exerted a most beneficial influence in the establishment of the educational institutions of that State. He was appointed Regent of the University, and was mainly instrumental in organizing its Medical Department. He was an active member of the American Medical As-

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sociation, and was elected president of that body in 1856.

— March 15, 1872, at San Francisco, California, JONATHAN LETTERMAN, M.D., formerly Medical Director of the Army of the Potomac, in which position he displayed remarkable executive ability and energy, establishing a new and very perfect ambulance system, a method of field-purveying, and a plan of field-hospitals.

Presbyterian Hospital of Philadelphia.—

In the list of the staff of this hospital given in the April number of the *News*, the name of Dr. Edward Wallace should have appeared as one of the physicians, instead of that of Dr. Ellerslie Wallace, who was not a candidate for the position.

FOREIGN INTELLIGENCE.

Fibroid Tumours of the Uterus.—M. GUSNIOR has communicated to the Academy of Medicine (*Med. Times and Gaz.*, March 23, 1872) an example of that rare occurrence, the disappearance of an uterine fibroma by absorption. In his opinion, founded on M. C. Bernard's experiments on the pancreas, when a fibroma or myoma thus disappears it first undergoes fatty degeneration; and, therefore, those agents should be employed in their treatment which tend to produce fatty transformation of the tissues or organs. The principal of these are arsenic, phosphorus, and lead; and it is to such medicinal substances recourse should be had much rather than to mercury, iodine, bromine, and the alkalies. The following are his conclusions: 1. The cure by absorption of certain fibroid tumours of the uterus, still sometimes disputed, may henceforth be regarded as a truth definitively proved. 2. These tumours may even undergo a rapid dissolution, some months sufficing in various cases for the complete disappearance of even large myomas. 3. In the cases hitherto observed, absorption has taken place during the period of activity of the genital affections; but the puerperal state has only quite exceptionally exercised an evident influence. 4. Uterine myoma may also disappear without surgical operation by two other

modes, viz., spontaneous expulsion, and gangrenous destruction or suppuration. But its disappearance by absorption, being the only mode completely exempt from danger and followed by cure, is that which should especially be sought to be induced. 5. Although the attempts made in this direction have almost constantly been unsuccessful or dubious in their results, some facts authorize us to believe that treatment is on the road of progress. 6. As far as can be judged by analogy, an uterine myoma, in order to become susceptible of absorption, must first undergo a fatty transformation of its mass. 7. The employment of steatogenic substances, such as arsenic, phosphorus, lead, etc., seems especially indicated in view of this result.

Spina Bifida cured by repeated Tapping and Pressure.—At the meeting of the Lisbon Society of Medical Sciences on February 17th (*O Correio Medico de Lisboa*, March 1st, 1872), Dr. Camara Cabral communicated a case of congenital spina bifida which he had successfully treated. The patient was a child aged twenty-five days, which was brought into St. Joseph Hospital on November 21st. It had in the lumbo-sacral region a swelling 40 centimetres in circumference, 17 in vertical and 10 in transverse diameter, and 6 in depth. It fluctuated, was transparent like a hydrocele, and appeared to contain not only fluid but some solid body. Pressure on it did not produce any convulsions, nor were there any paralysis or other symptoms denoting lesion of the spinal cord. It was, therefore, concluded that the tumour consisted exclusively of a hernia of the meninges, filled with fluid. On the 29th, it was tapped with a Dieulafoy's trocar, and 400 grammes of a transparent yellow fluid, containing an abundance of albumen, were removed. Compression was applied by means of adhesive plaster. No symptoms followed the operation, beyond some vomiting and loss of appetite. Some days later, the tumour having again enlarged, 250 grammes of liquid were removed; and on December 14, 425 grammes. The defect, which was found to be in the situation of the fourth and fifth

lumbar vertebrae, was gradually diminishing. On a fourth and a fifth occasion, puncture was performed at intervals of some days; the quantities evacuated being respectively 175 and 125 *grammes*, and the fluid being more highly albuminous than before. After the last two operations, there was some meningitis, which yielded to ordinary remedies. The child made a good recovery, and was exhibited at the meeting at which the case was described.—*Brit. Med. Journ.*, Mar. 23, 1872.

On the Surgical Treatment of Suppurating Ovarian Cysts and on Pelvic Adhesions in Ovariectomy.—Mr. T. HOLMES reported to the Royal Medical and Chirurgical Society a case in which chronic suppuration occurred in an ovarian tumour, after paracentesis had been performed for the first time. Ovariectomy was postponed for some months on account of the patient's condition. When it was performed the cyst was found extensively adherent in other directions, and so tightly wedged into the pelvis that it was impossible to reach its pedicle. It contained about a gallon and a half of fluid, of which about half was pure pus. The remains of the emptied cyst was dragged out of the abdomen, a clamp was applied to its neck (at a distance above the pedicle which could not be accurately ascertained), and the wound was closed. The patient recovered, and after her recovery no sinus was left, nor was any tumour to be felt. The symptoms of acute and chronic suppuration in ovarian cysts are discussed, and it is attempted to be shown that, if the general condition admits of it, the suspicion of suppuration is a reason for performing the operation instead of delaying it. The case is also used to show that, in some instances, the results of ovariectomy may be perfectly favourable, though pelvic adhesions have prevented the complete delivery of the tumour. If the neck of the cyst admits of being embraced in a clamp, the lower portion of it may be obliterated during the healing of the wound. The superiority of this method, when feasible, to the other courses which may be pursued in dealing with pelvic adhesions, is shown.

Mr. Bryant remarked that the accurate

diagnosis of a suppurating ovarian cyst was most important; that wasting, a hot skin, a permanently high temperature, bad appetite, local pain and tenderness on pressure, all indicated suppuration. If any doubt as to the diagnosis exists, he would be still more induced to interfere quickly, to remove the cyst if possible, or to take away as much as could be removed. He quoted a case to show the desirability of not leaving ligatures, and one also that showed the useful peculiarities of catgut.

Mr. Spencer Wells said that the diagnosis between an inflamed or suppurating ovarian cyst and peritonitis was generally easy, the chief point being that with a suppurating cyst there was considerable elevation in the temperature of the body, especially at night. In the morning it would range from 99° to 101°, and in the evening rise to 103° or 105°. In peritonitis, on the contrary—unless it were of the septic type—there was either no rise of temperature, or it might even fall to about 97°. But practice would be the same in either case. Whether the patient's life is in danger from a suppurating cyst, or from peritonitis set up by the presence of the cyst, or from escape of ovarian fluid into the peritoneal cavity, the cyst and fluid should be removed. He had learned this lesson from Sir Thomas Watson. Operating with Dr. Farre on a lady whose peritoneum was acutely inflamed from the bursting of an ovarian cyst, they were very fearful of an aggravation of the peritonitis; but Sir Thomas Watson, with the rare clinical sagacity which was his great characteristic, said, "Now the irritating cause is removed, we may hope the irritation will subside." And it did so in this case and in several others since. In one step of the operation he thought Mr. Holmes might have adopted a safer plan than separating the adhesions before emptying the cyst. These adhesions prevented any purulent or fetid fluid in the cyst from entering the peritoneal cavity, and in most cases it was generally better to completely empty the cyst before separating any adhesions. In cases where the cyst could not be removed a cure might sometimes be obtained by draining the cyst through

a tube and daily injections of iodine or carbolic acid.

Mr. Holmes, in replying, doubted if the diagnostic signs spoken of by Dr. Wells were positive as well as negative, because in some cases high temperature exists without suppuration, and in some cases of peritonitis the temperature has been persistently high.—*Med. Times and Gaz.*, Mar. 30, 1872.

Combination of Injection of Morphia with Inhalation of Chloroform.—MM. LABBÉ and GUYON recently read a paper at the Académie des Sciences, in which they gave an account of the results obtained in four cases in which they had tried the combined effect of hypodermic injection of morphia and the inhalation of chloroform. They were induced to enter on the investigation by having observed numerous experiments of M. Claude Bernard at the Collège de France, which demonstrated that, by such combination, very complete anaesthesia may be obtained by means of a much less quantity of chloroform than when this substance is employed alone. About the same time that M. Bernard was pursuing these researches, Professor Nussbaum, of Munich, with a view to the prevention of the pain consecutive to operations, injected in several cases the acetate of morphia, while the patient was under the influence of chloroform. In all his cases, pain continued suppressed, and sound sleep was prolonged for several hours after the operation.

While Professor Nussbaum, however, employed the morphia during the anaesthesia, MM. Labbé and Guyon injected it before this was produced, their object being also different—not the prevention of consecutive pain, but facilitating the production of anaesthesia, and rendering it less dangerous by reason of the smaller quantity of chloroform employed. At present they have only resorted to the means in the four cases, abstracts of which they now lay before the Academy. In the first of these, twenty minutes before the performance of an amputation, two centigrammes of muriate of morphia were injected into the thigh, and then

chloroform was administered. In seven minutes anaesthesia was complete, and was prolonged for a long time after the operation, which lasted seventeen minutes. The quantity of chloroform employed was twenty-eight grammes. In a case of ovariectomy, occurring in a girl of 20, the chloroform was given twenty minutes after the injection, and complete anaesthesia was produced in six minutes. The operation lasted an hour and forty-five minutes, and the expenditure of chloroform during all this time was only forty-eight grammes. The patient continued in a state of complete resolution, and after the operation was entirely calm, having felt no pain whatever. Incomplete as are their researches at present, the authors feel entitled to conclude: first, we can in man—as M. Claude Bernard has shown can be done in animals—obtain anaesthesia much more rapidly by combining the action of chloroform and morphia; secondly, that this anaesthesia is of longer duration, and may be kept up by smaller doses of chloroform, the risks of fatal accidents being thereby considerably diminished. They suggest also that the quantity of morphia injected may be somewhat larger than that which they employed, and that the injection might be conveniently practised a longer time before the operation.—*Med. Times and Gaz.*, March 23, 1872.

Death from Chloroform.—In the number of the *British Med. Journal* for April 6, 1872, there is reported a case of this occurring in a man to whom two and a half drachms of chloroform was administered, prior to an operation for iridectomy. Death occurred four minutes after the inhalation began. His heart was found to be fatty.

In the *British Medical Journal* for March 9, 1872, is reported another case of this which occurred at West Middlesex. A medical student aged 22 went to bed apparently well, and in the morning was found dead with a handkerchief applied to his mouth. He had been in the habit of inhaling chloroform to allay pain, and a verdict was given to the effect that death had resulted from this cause.

Liebreich's Chloride of Æthyl.—This substance was used instead of chloroform in Langenbeck's wards in 1870, and with the best results. It gave rise to no vomiting; sleep was induced easily, but was less profound than with chloroform. Of course it was expected that the latter would soon be superseded, and that the chloride would prove quite innocuous; but a death under its influence, which lately occurred, proved that absolute safety in the use of anæsthetics has not as yet been obtained.—*Lancet*, March 16, 1872.

Use of Nux Vomica in certain Neuroses of Organic Life.—M. BRUGNOLI (*Lyon Méd. et Journ. de Méd.*, Nov. 1871) has employed nux vomica successfully in the nervous movements of pregnancy, gastralgia, dyspepsia, hypochondriasis, nervous palpitations of the heart, nervous and periodic cough, asthma, and finally in albuminuria. This remedy acts either on the pneumogastric, or on the great sympathetic, or on the spinal cord. He records the case of a lady, afflicted with severe cough recurring every evening and lasting throughout the night, who was cured in two days by the use of nux vomica. Another patient was affected every evening with violent cough accompanied by catarrhal expectoration, and was also cured in two days by the use of the alcoholic extract of nux vomica mixed with the extract of gentian. Cough may always be allayed by this means, whether it be caused by bronchitis, by pneumonia, by pulmonary phthisis, or by emphysema. It proves a useful remedy also in cases of cardiac pulsations, and in irregular or too frequent action of the heart. In albuminuria, M. Brugnoli thinks the administration of nux vomica has retarded its progress to some extent, especially in cases of scarlatinal albuminuria.—*Practitioner*, Feb. 1872.

Chloral in Traumatic Tetanus.—DR. LAVO relates (*Annali Universali di Med.*, Feb.) three cases of severe traumatic tetanus which were successfully treated by means of chloral aided by the employment of the cold bath. The quantity of chloral used during the course of the first case amounted to 240 grammes, with twenty-five baths;

in the second to 147 grammes, with fifteen baths; and in the third to 140 grammes, with eleven baths.—*Med. Times and Gaz.*, March 30, 1872.

The Removal of Plaster of Paris Bandages.

—DR. CARSTENS gives a concise way of overcoming the obstacles presented by the plaster of Paris in the application of bandages. It should be good and freshly burnt. By mixing the plaster with cold water, or a solution of gum arabic, a paste is formed which will harden slowly; a quickly hardening paste can be made with a solution of sulphate of potassa or water-glass.

In reference to the removal of plaster of Paris bandages, Dr. Carstens remarks that this application is very insoluble in water (1 part in 438); in concentrated solutions of chloride of sodium, however, it is quite soluble (1 part in 122). Common salt has not only the advantage of being always on hand, but it does not injure polished instruments, as other solutions recommended for this purpose do; if a plaster of Paris bandage is moistened with a saturated solution of salt, the bandage becomes in a few minutes so yielding that a sharp knife finds little resistance; in the cut some more of the mixture should be applied, and, after repeating this three or four times, the bandage can be easily removed.

To clean the hand and nails of the operator, table-salt solution is also very useful.—*Medical Record*, Feb. 15, 1872.

Air in the Veins.—MR. TRÉLAT related (*British Med. Journal*, March 16, 1872) at a meeting of the Société de Chirurgie of Paris on Feb. 21st, an important case in which sudden death occurred in a patient from whom he was proceeding to remove a submaxillary tumour. The patient changed colour, and the heart-sounds ceased suddenly. Artificial respiration and electrization of the phrenic nerve induced some respirations and a slight return of colour after fifteen minutes, but ineffectually. At the necropsy, a small vein, opening into the external jugular, was found to have been partially divided; in the jugular was a long clot, segmented

by air-blebs, and other bubbles of air were found in one of the mediastinal veins and the posterior cardiac vein, and a very notable quantity of air in the right cardiac cavities. The question raised was, whether the death was due to this cause or to the action of the chloroform. M. Perrin and M. Marc Sée attributed the death to chloroform; and M. Giralddès believed that the entrance of air in the veins acted with the chloroform in producing the fatal result. He stated that, in three cases of death from chloroform, he had found gases in the heart, in the vena cava, and even in the veins of the pelvis. Roux had made a similar observation. But M. Depaul pointed out that the air in this case occupied only the veins going to the heart, and the wounded vein. M. Perrin and M. Depaul were much in favour of artificial respiration by a tracheal catheter and bellows.

Large Biliary Calculus.—Dr. THOROWOOD exhibited to the Pathological Society of London (*British Med. Journ.*, Feb. 24, 1872) a very large biliary calculus, two and three-quarter inches in length, and weighing five hundred and three grains, which was taken from the body of a female aged 67. It was interesting from its large size, and from its having produced no symptoms up to the woman's death.

Modification of the ordinary Test for the Biliary Acids.—M. STRASSBURG, of Bremen, suggests (*Pflüger's Archiv für gesammte Phys.*, Heft x. and xi, 1871) a modification of Pettenkofer's test for the presence of the biliary acids in urine, which promises to be serviceable clinically, and according to his statements is of extreme delicacy, enabling a trace not exceeding 3-100,000ths to be readily detected. He dips a slip of filtering paper into the urine suspected to contain the biliary acids, and to which a little cane-sugar has been previously added. The slip is withdrawn and dried; a drop or two of pure concentrated sulphuric acid is now applied to it by means of a glass rod. On holding the paper up to a strong light, a beautiful violet colour makes its appearance.—*Practitioner*, Feb. 1872.

Toxicological Notes.—It is stated in the *Chemical News* that Dr. James St. Clair Gray, assistant to the Professor of Medical Jurisprudence in the University of Glasgow, has read a paper to the Chemical Section of the Glasgow Philosophical Society, "On Certain Fallacies in the Means of Detecting some Poisons." He pointed out that Reinsch's test for arsenic is liable to fail when the arsenic has undergone oxidation to arsenic acid, or when it exists in the state of sulphuret. He advises the reduction of the arsenic acid by means of sulphite of an alkali; and in the instance of the sulphuret, he would boil with caustic potash and dialyse. He notes also that the presence of alcohol, chloroform, or ether, prevents the precipitation of the red iodide of mercury.—*British Med. Journal*, March 16, 1872.

Vivisections.—M. CLAUDE BERNARD, one of the greatest of living physiologists, in his recent work (*Leçons de Pathologie expérimentale*) points out the immense value of experimental pathological researches, and the necessity for the construction of special physiological laboratories (like those of Kühne at Amsterdam, and Ludwig at Leipzig) wherever physiology is taught, in order that theory and practice may go hand in hand. Referring to the absurd scruples of the antivivisectionists, he points out the necessity that exists for the daily slaughter of a large number of the lower animals, and gives the following anecdote in a note: "In one of his campaigns the Duke of Burgundy, son of the Grand Dauphin, wrote to Fénelon to ask whether he might encamp his army under the walls of a nunnery, as, however objectionable in point of morality, the position was peculiarly advantageous for the prosecution of the war. Fénelon promptly replied, 'Burn the nunnery, but gain the battle.' Now, Fénelon was certainly not a man of lax morals, nor a man of anti-christian spirit, nor a violent character; but he recognized that war has its necessities, which must be obeyed if success is to be obtained. Physiology, too, has its necessities, and these must be submitted to, or all progress must be renounced.—*Lancet*, March 30, 1872.

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The excellence of this book is one explanation of our not having reviewed it sooner. Taking it up from time to time, we have been freshly interested in its various chapters, and so been led to defer writing our opinion of it. It is one of those works with which we are happily becoming familiar, as coming to us from time to time from across the Atlantic, which contain all that is good in European works of the same kind, together with much that is original, both in reflection and observation. It is astonishing how well the American writers succeed in gleanings, and yet giving a fresh character to their books. This work is an illustration, and pervading every chapter of it is a spirit of sound judgment and common sense, without which any work on any department of the practice of medicine is, to use the mildest word, defective. We are sorry that we cannot give further illustrations of the excellence of this book.—*London Lancet*, Sept. 4, 1869.

After an examination of this book, we think we are not mistaken in welcoming its writer as a new authority in medical literature on the diseases of children. The sources of his information are copious, and he seems to have made careful use of them. We had intended to support these opinions by quotations, but the range of the work is so comprehensive, and our readers can so much better form a notion of the industry and good judgment of its author by an extended perusal of it, that we have concluded to simply refer them to the book itself, and will only add that it is written in the clear and unambitious style befitting a scientific work.—*St. Louis Med. and Surg. Journal*, May 10, 1869.

Our fellow-townsmen, Dr. Smith, is well known among us as an indefatigable worker, and one who has devoted the major part of his time to the

study, theoretically and practically, at the bedside and in the dead-house, of the diseases of children. From a careful perusal of his work we agree with the author, that while he has respected the opinions of previous writers, and has adopted them so far as they appeared to be correct, he has depended much more for the material of his treatise on clinical observation and the inspection of the cadaver. Most heartily do we wish the work the success it so richly deserves.—*Am. Journ. of Obstetrics*, &c., May, 1869.

The author of this volume is well known as a valued contributor to the literature of his specialty. The faithful manner in which he has worked in the public institutions with which he has been connected, the conscientious regard for truth which has for years characterized all his researches, the great amount of experience which he has been enabled to acquire in the treatment of infantile diseases, and the care which he has accustomed himself to take in the study of the significant facts relating to the pathological anatomy of the diseases of childhood, eminently fit him for the task which he has taken upon himself. The remarkable facility of bringing out salient points and stating concisely other less important facts, enables him to crowd within a small compass a vast amount of practical information. The attention given to the treatment of the various maladies, as well as the presentation of all the recently accepted pathological views, make it one of the most valuable treatises, within its present compass, that can be placed in the hands of any seeker after truth. The volume as a whole will still further establish for the writer a permanent and enviable reputation as a careful observer, an impartial interpreter, a safe and trustworthy advisor, and a modest and untiring student.—*N. Y. Med. Record*, March 15, 1869.

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